MEDICARE CARRIER ASSESSMENT OF NEW TECHNOLOGIES

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EXECUTIVE SUMMARY

PURPOSE AND OBJECTIVES

This inspection report reviews technology assessment activities by the Medicare carriers. We examined how the carriers identify new technologies, and how they make decisions about coverage and pricing for new devices, diagnostic tests, procedures, and treatment modalities. Also, we addressed how the carriers perceive their overall performance in carrying out technology assessment activities.

BACKGROUND

Total Medicare expenditures increased at an average annual rate of 12 percent over the years 1976 to 1988, but Medicare Part B expenditures increased at an annual rate of 18 percent over the same years. In dollar terms, the Part B payments made by Medicare carriers increased an average of $1.8 billion a year, to $26.1 billion in 1988. Studies conducted by the Health Care Financing Administration (HCFA) and the Office of Technology Assessment indicate that new health care technologies account for a substantial portion of the annual increase.

In their role as processors of approximately 400 million claims annually for health care items and services, the Medicare carriers are usually the program's first point of contact with technologies new to the medical marketplace.

The carriers are called upon to identify and to make coverage and pricing decisions about almost all new health care technologies. Ordinarily the carriers decisions are final; HCFA carries out national assessments on only 20 or 30 new technologies a year.

METHODOLOGY

We based this inspection on:

- structured interviews with representatives of all the Medicare carriers that were responsible for processing Part B claims during the summer of 1988;
- written information provided by the carriers concerning their experiences in assessing five particular new technologies;
- discussions with outside observers, including representatives of manufacturers, insurance organizations, and national organizations active in assessing health care technology; and
- the HCFA's Medicare Part B payment data records, from which we derived payment amounts for particular codes provided by the carriers.

MAJOR FINDINGS

Our findings on carrier assessment of new technologies reflect three major themes: (1) limited information about emerging technologies, (2) inconsistent coverage and pricing decisions, and (3) economies not realized. We reflect these themes in our findings:

> *The HCFA has moved to improve carrier coverage and pricing. However, carriers desire additional and more timely information on coverage and pricing matters.*
>
> *Carriers are inconsistent in coverage and pricing decisions involving new technologies. Some of the variations are unwarranted (particularly in pricing).*
>
> *Carriers have no system for ensuring that payments for new technologies decrease in response to decreasing costs for delivering an item or service.*

We organized our individual findings according to the Medicare carriers' process for assessment of new technologies: (1) identifying the new technology as such, (2) deciding whether or not to include it as a Medicare covered item or service, and (3) deciding on the reimbursement amount, or price, to allow for it.

Overall Performance

- The carriers' self-rankings indicate substantial room for improvement in the way they assess new technologies. In only one of four categories do a majority rate the carrier performance as good.

Identification

- More than one-third of all carriers have experienced major problems with the identification of new technologies. Included among them are 6 of the 11 largest carriers.

Coverage

- Most carriers use professional acceptance as a major criterion when making coverage decisions about new technologies. Less than 10 percent of the carriers cite cost effectiveness as a major criterion.

- Respondents at one-third of the carriers say that the carriers, as a group, are at most minimally consistent in making coverage decisions about new technologies.

- When they make coverage decisions about new technologies, most carriers get input from such operationally related sources as HCFA, other carriers, or their own private business segments.

- However, the carriers strongly support the concept of a national clearinghouse that would share information about coverage issues among carriers.

Pricing

- Most carriers use more than one method to set reimbursement amounts for new technologies. The method used by the most carriers is that of comparison to similar codes.

- Reimbursement amounts allowed for new technologies vary significantly from one carrier to another. The variation is much greater than that accounted for by differences in per capita personal income across the country.

- Although about half the respondents think that the cost of providing a new technology tends to decrease during the 2 or 3 years following its introduction, none identify any special initiatives to avoid overpayments by Medicare in such instances.

RECOMMENDATIONS

The HCFA should continue to improve its own capability and that of the carriers to identify emerging technologies and to make more informed, explicit, and consistent coverage and pricing decisions concerning new technologies.

Toward this end HCFA should:

(1) continue to improve communication among the carriers through increased use of national and regional technical advisory groups,

(2) continue to improve carrier access to comparative Medicare payment information about new technologies,

(3) review the performance of carriers in identifying, covering, and pricing specific new technologies, and

(4) cooperate with the Public Health Service in proactively and routinely compiling and rapidly disseminating information on new health care technologies through clearinghouses or other appropriate means.

The HCFA should seek legislative authority to broaden the bases upon which it can establish reimbursement amounts for new and emerging technologies other than physician services. This authority should be available to HCFA both at the time of the initial coverage decision and as the technology matures.

The legislation should supplement current authorities by allowing HCFA to:

(1) limit initial payments based on a consideration of the cost of developing and delivering the technology,

(2) subsequently reduce the allowable charges for new technologies as they mature in order to take advantage of reduced costs, and

(3) establish regional or national reimbursement limits based on simple and easily verifiable criteria such as the mere existence of substantial variation in reimbursement rates.

COMMENTS AND OIG RESPONSE

In its written comments and at subsequent meetings, the HCFA recognized that problems exist with the carrier assessment of new technologies and noted that it has taken numerous recent initiatives to improve technology assessment. Some of the actions we recommended are included among the HCFA initiatives. The HCFA was concerned that our findings, at least in part, may no longer be valid because of its recent efforts. It asked the OIG to conduct an additional study aimed at assessing the effectiveness of its recent initiatives.

We agree that HCFA has moved to resolve the problems addressed in this study. For this reason we have removed from this report a statement, contained in the draft report, that the current procedures for carrier coverage and pricing of new technologies constitute a material internal control weakness within the meaning of the Federal Manager's Financial Integrity Act. We have agreed to work with HCFA in evaluating the effectiveness of its efforts to improve carrier assessment of new technology.

The HCFA agreed that additional legislative authority would help it improve coverage and pricing decisions for nonphysician services. The HCFA believes that physician payment reforms recently enacted in the Omnibus Budget Reconciliation Act of 1989 (OBRA-89) will provide an appropriate framework and sufficient authority to improve coverage and pricing decisions relating to physician payments.

We agree and we have modified our legislative recommendations to focus exclusively on nonphysician services. But we are concerned about the practical aspects of the new physician payment reform provisions. In order to develop fee schedules for new and emerging treatment modalities, HCFA must identify them. We believe that the ability to identify emerging new technologies is the area of greatest weakness in the current system. We are hopeful that HCFA's recent initiatives will be effective in addressing this weakness. We will know more when our future evaluations, mentioned above, are completed.

We also remain concerned that the many Part B payments for nonphysician services, such as durable medical equipment, prosthetics, and physiological testing, are not covered by the payment reforms of OBRA-89 . We believe our legislative proposals are particularly important for these nonphysician services.

The HCFA disagreed with our recommendation for disseminating coverage and pricing information among carriers through a clearinghouse because it would not be cost effective, and because carriers do not use current clearinghouses. We continue to support this recommendation. In our survey, the carriers themselves asked for this kind of assistance. We believe the current clearinghouses are too passive and often impracticably slow because they rely upon specific requests from the carriers. What we have in mind is a more proactive and orderly dissemination of information. We think that a more proactive clearinghouse would be an effective way to do this, but we would support any other technique provided it is aggressive and systematic. We have modified the wording of the recommendation to make our intent more clear.

The Public Health Service and the Office of the Assistant Secretary for Planning and Evaluation both recognized the need to improve carrier coverage and pricing decisions. They both supported the idea of a clearinghouse to share coverage and pricing information.

The Health Insurance Association of America and the Health Industry Manufacturers Association also commented on our draft report. They agreed with most of our findings and recommendations.

The text of all comments and our detailed responses to them are in appendix D.